

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
Linda		R.	Anderson		Month Day Year Aug 14 1968		L 4 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Female		Cau		Feb. 13, 1894		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		Cecil				Cecil			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Port Deposit		Main Street		Teacher		J.T.I.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Cecil		Port Deposit				Main Street	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost
George		M.	Anderson	Sr	Emma		L.	Brown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		217-24-1901		Dr. George M. Anderson Jr.		Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Massive Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Coll. H.s. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 wks. 2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from July 1964, to 8-18, 1968, that (I) (we) lost saw the deceased alive on 8-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. H. Richards Jr.					DEGREE MED. DIRECTOR		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/18/68
22d. PHYSICIAN'S NAME (Type) G. H. Richards Jr.					22e. ADDRESS Port Deposit, Maryland				
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Aug. 17, 1968		West Nottingham Cemetery		Colona, Cecil, Md.			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, erryville, Md.					25a. REC'D BY REGISTRAR DATE AUG 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



George Washington  
217-21-171  
The George Washington Foundation  
Washington, D.C.  
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George Washington  
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The George Washington Foundation  
Washington, D.C.  
20540

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11377										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11385									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) <b>GEORGE B. BORLAND</b>					First Middle Last					2a. DATE OF DEATH <b>8</b> Month <b>15</b> Day <b>68</b> Year					2b. HOUR <b>2:40 P</b>														
3. SEX <b>M</b>			4. RACE <b>W</b>			5. DATE OF BIRTH <b>1-4-93</b>			6. AGE (In years last birthday) <b>75</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CECIL</b>																				
10. CITY OR TOWN OF DEATH <b>ELKTON</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>UNION</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TAXI DRIVER</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>TAXI</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>					13b. COUNTY <b>CECIL</b>			13c. CITY OR TOWN <b>ELKTON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>231 E. MAIN ST.</b>															
14. FATHER'S NAME <b>HENRY</b>					First Middle Last <b>BORLAND</b>					15. MOTHER'S MAIDEN NAME <b>MARGARET</b>					First Middle Last <b>ANDERSON</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <b>NO</b>					16b. SOCIAL SECURITY NO. <b>216-09-2949</b>					17. INFORMANT <b>TEMPA D. BORLAND</b>					Address <b>ELKTON, MD.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer of Prostate Spread</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>177X</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>														
															<b>12 hrs.</b>														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> , 19 <b>68</b> , to <b>8/15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8/15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>Joseph S. Lanz</b>										DEGREE <b>MD.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>8-16-68</b>									
22d. PHYSICIAN'S NAME (Type) <b>JOSEPH S. LANZI</b>										22e. ADDRESS <b>ELKTON, MD.</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE <b>8-17-68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>CHERRY HILL METH</b>					23d. LOCATION (City or Town) (County) (State) <b>CHERRY HILL CECIL MD.</b>														
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>										ADDRESS <b>ELKTON, MD.</b>					25a. REC'D BY REGISTRAR <b>DATE AUG 19 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
JAMES		GRAYSON	BOUCHELLE	AUG. 1 68		9:10 PM			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W		DEC. 7, 1878		89 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
CECILIA	M. S. A.				CECIL				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
ELKTON		UNION		RET. FARMER			FARM		
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		CECIL		ELKTON				107 BRIDGE ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
AUGUSTUS				BOUCHELLE	ELIZABETH				SATTERFIELD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		217-20-9502A		KATHRYN H. PURNELL		ELKTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Heart Disease</u> (b) <u>Generalized Atherosclerosis</u> (c) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. 18 hrs. 1-2 yrs. 5-8 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/1 1968, to 8/1 1968, that (I) (we) last saw the deceased alive on 8/1 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
PETER STAVRAKIS M.D.						8/1/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
PETER STAVRAKIS M.D.		ELKTON MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8-3-68		BETHEL		CHESAPEAKE CITY		CECIL MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. JOHNSON		ELKTON, MD.		AUG 5 1968		Charles Judge			

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11373										
11387										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Robert A. Boyd						Month Day Year		3:55 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male			White		May 8, 1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Penna.			USA				Cecil			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hospital			Storekeeper		Grocery		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Cecil		North East				12 Church St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Samuel S. Boyd			Jane Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			219-10-4900		T. Davis Boyd		North East, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 6 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1966, to 8/11/68, 19, that (I) (we) saw the deceased alive on 8/10/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
Robert L. Gray M.D. DEGREE			8-12-68							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Robert L. Gray			Elk-- Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			8-14-68		West Nottingham Presby.		Cecila Cecil Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Grant Funeral Home			Box 22 North East, Md.			DATE AUG 16 1968		Charles J. Jones		

11581

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

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6. [Illegible]

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97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]



OFFICE OF THE SECRETARY OF DEFENSE  
11581





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VR A15 (4)  
30M REV. 1/68

11380										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11388																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
Winter										DAY										Brown																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
Male										white										11-14-1874										93 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MD										USA																				Cecil																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Rising Sun										Calvert Manor N.H.										Farmer																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
Md										Cecil										CALVERT																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
ELLIS										BROWN										EDITH M. HOOPES																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
NO										(If yes give war or dates of service)										220-34-6792										CLARENCE BROWN										NOTTINGHAM, PA.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																																											
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										4409										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				(b)										Generalized Arteriosclerosis 40 years																													
																				(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																																											
4500																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										19																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																																																											
21b. SIGNATURE										21c. DEGREE										21d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
Ernest W. Senter										M.D.																				July 8, 1962																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
ERNEST W. SENTER, M.D.										Rising Sun, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
										8/11/68										FRIENDS CEMETARY										CALVERT CECIL, MD.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
RALPH M. REED										Rising Sun, Md.										AUG 12 1968										[Signature]																													

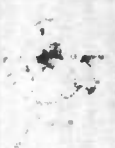
11380

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

11380



Plant Name	Wisteria
Local Name	Wisteria
Family	Leguminosae
Country	USA
State	California
County	San Diego
Locality	San Diego Botanical Garden
Collector	W. L. Wagner
Date	April 1941
Number	11380
Notes	Fls. white, fragrant.



11380

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11388									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
CAROLINE		CALHOUN						<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 8-24 19 11:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD
Female	Negro	3-17-56		12 YRS	MONTHS DAYS		HOURS MIN		August Day 24, Year 19 68 11:00 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
N.Y.		U.S.A.				CECIL Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital				STUDENT		SCHOOL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
N.Y.				N.Y.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1735 Madison Avenue	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
HAROLD		CALHOUN		DELOISE		MORRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		NONE		HAROLD CALHOUN		N.Y. CITY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-cranial injuries</u> 812.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
8164									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		10:30 P.M. 8-24 1968		Passenger in auto-auto collision					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
		highway		Intersection #98 and Md.#279		Elkton Cecil Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 25, 1968	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8-31-68		FERNCLIFF		HARTSDALE N.Y.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
PIPPIN FUNERAL HOME		ELKTON MD		DATE AUG 28 1968		y Charles Judge			

08871

ALBANY, NEW YORK, 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11382		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				11390		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR
NELSON CHARLES CHADWICK SR						AUG. 24, 1968		5:15A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE		WHITE		MAY 10, 1893		23 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
Md		USA				CECIL		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
ELKTON			UNION HOSP.			FARMER		CONST
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Md.			CECIL		CHES. CITY			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
JOHN			CHADWICK			ALICE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
No			WW-1		ELSIE MAY CHADWICK			CHESAPEAKE CITY, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia, severe</u> <u>5369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>undet</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>week</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>578 X</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-23</u> , 19 <u>68</u> , to <u>8-24</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>8-24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>T.D. Johnson</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>8-26-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>T.D. Johnson M.D.</u>					22e. ADDRESS <u>123 Singler Ave, Elkton</u>			
23a. BURIAL, CREMATION, RENOVATION (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		AUG 27, 1968		JOHN TOWN CEMETERY		JOHN TOWN CECIL Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME			ELKTON MD			DATE AUG 28 1968		<u>Charles Judge</u>

02080

CERTIFICATE OF DEATH

2000

under  
water

premises, service  
center, water, plumbing

1

8-24-83 8-24-83 8-24-83

Old John  
The Johnsons  
1982-1983



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>ESSEX</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MASSACHUSETTS</u> b. COUNTY <u>ESSEX</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b <u>1 Wk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WAKEFIELD</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>61 UNION HOSPITAL</u>						d. STREET ADDRESS <u>29 CHESTNUT ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VERA</u> Middle <u>LEONA</u> Last <u>DUNN</u>						4. DATE OF DEATH Month <u>AUG</u> Day <u>11</u> Year <u>1968</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 6 - 1908</u>		9. AGE (In years last birthday) yrs. <u>60</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME MAKING REST.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>CANADA NOVA SCOTIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES ORDE</u>						14. MOTHER'S MAIDEN NAME <u>BESSIE ORDE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>JEAN WIEGAND</u> Address <u>155 BALEHIST WAKEFIELD MASS</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>8 MONTHS</u> (c) <u>8 MONTHS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL OUT OF CHAIR WHEN SHE FELT TANGS GETTING BACK</u>									
20c. TIME OF INJURY Month, Day, Year <u>8/11/68</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PUBLIC STREET</u>				20f. (City or town) (County) (State) <u>CHAMPESTOWN MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Henry V. Davis</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVED (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>8-15-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST GLADE</u>				23d. LOCATION (City or Town) (County) (State) <u>WAKEFIELD, MASS.</u>	
24. FUNERAL DIRECTOR <u>DIPPIN FUNERAL HOME</u>						ADDRESS <u>Elkton</u>		25a. REC'D BY REGISTRAR <u>William Judge</u>				25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	

18212

18212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11384 CERTIFICATE OF DEATH 11392									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Remonia			V. Elmer			August 30, 1968			1:40 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		March 6, 1931			37 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Virginia		U.S.A.					Cecil Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Elkton			Union Hospital			Housewife			--
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Cecil		Elkton		R.D. 4		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
David C. Campbell			Laura Justice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					Mrs. Ann Smith, Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>7123</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>7220</u> (b) <u>hypoadrenalism; Gouty enterocolitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>prolonged steroid Rx &amp; Rheumatoid arthritis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
									<u>1 hr.</u>
									<u>2 hrs.</u>
									<u>20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Paticular with partial infarct of brain;</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2</u> , 19 <u>68</u> , to <u>Aug. 30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Aug. 30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edgar E. Folk, M.D.</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9/9/68</u>			
22d. PHYSICIAN'S NAME (Type) Edgar E. Folk, M.D.				22e. ADDRESS Newark, Del.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		9/1/68		Gilpin Manor Memorial Park			Elkton, Md.		
24. FUNERAL DIRECTOR <u>Joseph E. Hicks</u> Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR DATE <u>SEP 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

• • •

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/58

11385										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										11393																																																																					
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																																					
First ARTHUR										Middle FOLLETT										Last FOLLETT										Month August										Day 28,										Year 1968										1:20 AM																													
3. SEX Male										4. RACE White										5. DATE OF BIRTH 8-14-94										6. AGE (In years lost birthday) 74										YRS.										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country) England										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. COUNTY OF DEATH Cecil										Md.																																																	
10. CITY OR TOWN OF DEATH Perryville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VAH., Perry Point, Md.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hardwood Finisher										12b. KIND OF BUSINESS OR INDUSTRY																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD										13b. COUNTY BALTIMORE										13c. CITY OR TOWN Baltimore										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 1116 Cooks Lane																																																	
14. FATHER'S NAME First Unknown										Middle Unknown										Last Unknown										15. MOTHER'S MAIDEN NAME First Unknown										Middle Unknown										Last Unknown																																							
16a. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) Yes										(If yes, give year or dates of service) WW I										16b. SOCIAL SECURITY NO. 213-12-6706										17. INFORMANT VA Hospital records, Perry Point, Md.										Address																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2959 IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF schizophrenia (b) Chronic brain syndrome assoc. w/chronic DUE TO, OR AS A CONSEQUENCE OF years (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 3007 Arteriosclerosis, generalized																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																																					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																																					
22a. I certify that (a) (this hospital) attended the deceased from 6-4-68, 19, to 8-28, 19 68, that (b) (my) view of the deceased after death was <del>xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx</del> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																																									
22b. SIGNATURE A. L. MOONEY, M.D.										DEGREE ATTENDING PHYS.										MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 8-28-68																																																											
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.										22e. ADDRESS VA Hospital, Perry Point, Md.																																																																															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 9/2/1968										23c. NAME OF CEMETERY OR CREMATORY East Pate Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore Md.																																																											
24. FUNERAL DIRECTOR Lee A. Patterson										ADDRESS Perryville, Md.										25a. REC'D BY REGISTRAR SEP 3 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																																																											

58321

58321

UNITED STATES DEPARTMENT OF JUSTICE

1968-11-28

1968-11-28

1968-11-28

TO: DIRECTOR, FBI (100-441100)  
FROM: SAC, NEW YORK (100-158866)  
SUBJECT: [REDACTED]  
RE: [REDACTED]

UNKNOWN

UNKNOWN

100-441100-1000 (100-158866-1000)

2-10-68

Chronic brain syndrome, chronic

schizophrenia

years

Chronic brain syndrome, chronic

Arteriosclerosis, generalized

X

100-158866-1000

100-158866-1000

100-158866-1000

8-25-68

NY Hospital, Fort Belvoir, VA

NY Hospital, Fort Belvoir, VA

NY Hospital, Fort Belvoir, VA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11386

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

11394

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR P. M.			
Ida C. Ford					Aug. 7 1968		8:00 P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 22, 1921		6. AGE (In years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.				
10. CITY OR TOWN OF DEATH North East		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 110 Beech St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 110 Beech St.		
14. FATHER'S NAME John W. Smith		First	Middle	Lost	15. MOTHER'S MAIDEN NAME Alberta Kulp		First	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 166-18-9574		17. INFORMANT Burns A. Ford		Address North East, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4301</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-29, 1967</u> , to <u>7-12, 1968</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>7-12, 1968</u> , and that in (my) ( <del>was</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.										
22b. SIGNATURE <u>Jay S. Barnhart Jr.</u>					DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-9-68		
22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.					22e. ADDRESS 4 Mauldin Ave. North East, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-10-68		23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.				
24. FUNERAL DIRECTOR <u>Paul P. Crouch</u> Grant Funeral Home					ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DATE AUG 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Anna			E.		Foster		August		11, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR	
Female		White		Oct. 12, 1886			81		11:50	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			U.S.A.				Cecil			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Elkton			Union Hospital			Housewife			---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Cecil		Elkton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		115 1/2 E. Main St.	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
John			William		Mahoney		Ellen		Terry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
No						Mrs. Ann Gilbert, North East, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) <u>Smile + arteriosclerotic cardiovascular disease + congestive heart failure.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/2, 1968</u> , to <u>8/11, 1968</u> , that (I) (we) last saw the deceased alive on <u>8/11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED	
Jay S. Barnhart, Jr.									8-15-68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
Jay S. Barnhart, Jr.			North East, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		8/15/68		Elkton Cemetery			Elkton, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hicks Home for Funerals, Elkton, Md.						DATE		AUG 19 1968		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ROBERT			L			GONCE			Month 8 Day 18 Year 1968 4:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male		White		6-18-00			68 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U.S.A.					Cecil Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Perryville			VAH., Perry Point, Md.			Store Operator			Dry Goods
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md			Cecil			Elkton		13e. STREET AND NUMBER	
								137 E. Main St.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JOHN E. GONCE			ELIZA BRATTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
Yes WWII			215-12-8180			VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									10-25 days
IMMEDIATE CAUSE (a) Myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 7-24-68, to 8-18-68, that the deceased died on 8-18-68, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
E. E. Folk III, M.D.								8-19-68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS	
E. E. FOLK III, M.D.								VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		8-21-68		SILVERBROOK		WILMINGTON CASTLE DEL			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
PIPPIN Funeral Home 259 E. Main Elkton, Md.				AUG 20 1968		J. Charles Judge			



UNITED STATES DEPARTMENT OF JUSTICE

10-25-58

MEMORANDUM

TO: THE ATTORNEY GENERAL

FROM: [illegible]

DATE: [illegible]

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

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21. [illegible]

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26. [illegible]

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28. [illegible]

29. [illegible]

30. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M. REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Elizabeth			J. Henry			August 25, 1968			2:25 p.m.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		May 29, 1887			81 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U.S.A.						Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Hospital											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Cecil			Elkton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Main St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Harry D. Henry			Mary D. Johnson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No						Mrs. Daniel W. Henry, Elkton, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>														
4270 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) <u>CONGESTIVE HEART FAILURE</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
4341 <u>Broncho pneumonia</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>  </u> , to <u>Aug. 25, 1968</u> , that (I) (we) lost saw the deceased alive on <u>8/25/68</u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
<u>Robert L. Gray</u>														
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Robert L. Gray M.D.			123 W. High St. Elkton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			8/27/68			Elkton Cemetery			Elkton, Md.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
<u>Ralph E. Hicks</u>			DATE <u>SEP 16 1968</u>			<u>Charles Judge</u>								
Hicks Home for Funerals, Elkton, Md.														

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
ALLOYD C. HOLLAND						Month 8 Day 23 Year 68		10:12 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Male		White		7-12-06		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Washington, DC		U.S.A.				Cecil			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Perry Point		Veterans Administration		Mechanic auto.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia				N. Arlington				2637 N. Upshur Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Holland (L) Rose Daily (D)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes WW II			577-48-1839		VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> <u>Bronchogenic carcinoma with wide spread metastasis</u>								5 months	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia lower lobes</u>								10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
<u>1621</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 24</u> , 19 <u>68</u> , to <u>Aug. 23</u> , 19 <u>68</u> <del>xxxxxx</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S. Goldgraben</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <u>8-24-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>S. GOLDGRABEN, M.D.</u>								22e. ADDRESS <u>VA Hospital, Perry Point, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		23b. DATE <u>8-24-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>3201 Bladensburg RD Wash., DC</u>			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>NALLEY'S Funeral Home, 3200 Rhode Island Wash. DC</u>				DATE <u>AUG 27 1968</u>		<u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 19-13-68 Film 404   |  |  |  |  |                 |   |  |  |                                   |
|---|--|--|--|--|-----------------|---|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                 |   |  |  |                                   |
| CERTIFICATE OF DEATH  |  |  |  |  |                 |   |  |  |                                   |
| 11399   |  |  |  |  |                 |   |  |  |                                   |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last  |  |                 | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |
| PARKER  |  |  | A. KEEN JR.  |  |                 | AUGUST 10 1968  |  |  | 925 AM                            |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |                 | 6. AGE (In years last birthday)   |  | 7. IF UNDER 1 YEAR   |                                   |
| MALE  |  | WHITE  |  | NOV. 25, 1942  |                 | 23 YRS.   |  | MONTHS DAYS HOURS MIN.   |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 | 9. COUNTY OF DEATH  |  |  |                                   |
| Md.   |  | USA  |  |  |                 | CECIL   |  |  |                                   |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| ELKTON  |  |  | UNION HOSP.  |  |                 | AUTO  |  |  | MECH                              |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |                 | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| Md  |  |  | CECIL  |  |                 | ELKTON  |  | 227 W. HIGH ST   |                                   |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |                 |   |  |  |                                   |
| First Middle Last   |  |  | First Middle Last  |  |                 |   |  |  |                                   |
| PARKER A. KEEN SR   |  |  | JANE TRIMBLE   |  |                 |   |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address  |  |                                   |
| No  |  |  | -  |  | JANE T. KEEN    |   | ELKTON, MD   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                 |   |  |  |                                   |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                 |   |  |  |                                   |
| IMMEDIATE CAUSE (a) 153.0   |  |  |  |  |                 |   |  |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis   |  |  |  |  |                 |   |  |  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Primary site: Cecum  |  |  |  |  |                 |   |  |  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |                 |   |  |  |                                   |
| 153.0   |  |  |  |  |                 |   |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |  |                                   |
| 6-25-68   |  | Adenocarcinoma of the Cecum Partial intestinal obstruction                   |  |  | NO              |   |  |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                 |   |  |  |                                   |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |                 |   |  |  |                                   |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                 |   |  |  |                                   |
| While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |                 |   |  |  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-14-1968, to 8-10-1968, that (I) (we) last saw the deceased alive on 8-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                 |   |  |  |                                   |
| 22b. SIGNATURE  |  |  | DEGREE   |  | ATTENDING PHYS. |   | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                  |
| Cristobal Vela  |  |  |  |  |                 |   |  |  | 8-12-68                           |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS   |  |                 |   |  |  |                                   |
| Cristobal Vela  |  |  | 123 W. High St. Elkton, Md.  |  |                 |   |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                 | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |
| BURIAL  |  | 8-13-68  |  | ELKTON CEM.  |                 | ELKTON CECIL Md   |  |  |                                   |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |                 | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |
| DIPPIN FUNERAL HOME   |  | ELKTON, MD   |  | AUG 13 1968  |                 | J. J. J. J.   |  |  |                                   |







# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-102. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 11392  |  |                         |  |   |  |   |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11400   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print) First Middle Last<br><b>LARRY F. KING</b>   |  |                         |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><b>August 2, 1968</b>   |  |  |  |  |  |  |  |  |  | 2b. HOUR<br><b>7:18M</b>  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br><b>Mar. 31/47</b>   |  | 6. AGE (In years last birthday)<br><b>21</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>August</b> Day <b>2</b> , Year <b>1968</b>              |  |  |  |  |  |  |  |   |  | 2d. HOUR<br><b>7:18A</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>Cecil</b>   |  |  |  |  |  |  |  |   |  | Md.                      |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Elkton</b>   |  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Union Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ground Man</b>  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electric Co.</b>                                     |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Penna</b>  |  |                         |  | 13b. COUNTY<br><b>Chester</b>   |  |   |  | 13c. CITY OR TOWN<br><b>Oxford</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br><b>Box 202, R.D. 3</b> |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Robert H. King, Jr.</b>  |  |                         |  |   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Marie Williams</b>  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |                         |  |   |  |   |  |   |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT ADDRESS<br><b>Elizabeth Bryant King, Oxford, Pa.</b>                  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Craniocerebral Injuries</b><br><b>8199</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |                         |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>8250</b>  |  |                         |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  |   |  |   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br><b>8-1/2 19 68</b>  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subject was found pinned in pick-up truck</b>                         |  |  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Street</b>         |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>RT. 273 Rd.3 Elkton Cecil M.D.</b>   |  |  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Ronald N. Kornblum, M.D.</b>  |  |                         |  |   |  |   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |  |  |  |  |  |  |  |  |  | 22b. DATE SIGNED<br><b>August 2, 1968</b>   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>8/6/68</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Meth. Cemetery, Lewisville, Cecil, Md.</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cecil, Md.</b>                           |  |  |  |  |  |  |  |   |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ralph E. Hicks</b><br><b>Hicks Home for Funerals, Elkton, Md.</b>   |  |                         |  |   |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 9 1968</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |  |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |

1100

1100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |   |   |                        |  |
|--|--|--|--|--|---|--|---|---|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |   |   |                        |  |
| 11393 CERTIFICATE OF DEATH 11401   |  |  |  |  |   |  |   |   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |                        |  |
| GEORGE   |  |  | W. LEONARD   |  | Month 8 Day 13 Year 68  |  |   | 11:15 am  |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |                        |  |
| Male   |  | White  |  | 5-9-97   |   | 71 YRS.  |   |   |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |                        |  |
| West Virginia  |  | U.S.A.   |  |  |   | Cecil Md.  |   |   |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY               |                        |  |
| Perry Point  |  |  | Veterans Administration  |  |   |  |   |   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |  |
| Pennsylvania   |  |  |  |  | Springfield   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | 687 Andrew Road        |  |
| 14. FATHER'S NAME  |  |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME  |  |   | First Middle Last                               |                        |  |
| Unknown  |  |  |  |  | Unknown   |  |   |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |   |   |                        |  |
| Yes  |  |  | WW I   |  | 217-54-9513 VA Hospital Records, Perry Point, Md.                   |  |   |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |                        |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u>   |  |  |  |  |   |  |   | 2 Wks   |                        |  |
| 5901 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pyelonephritis</u>   |  |  |  |  |   |  |   | 2 Wks   |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>6000</u><br>(c)  |  |  |  |  |   |  |   |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Chronic Brain Syndrome Assoc. with Cerebral Arteriosclerosis.</u>  |  |  |  |  |   |  |   |   |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |   |                        |  |
|  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |   |   |                        |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |  |   |   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |   |                        |  |
|  |  |  |  |  |   |  |   |   |                        |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 22</u> , 19 <u>68</u> , to <u>Aug. 13</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |   |                        |  |
| 22b. SIGNATURE <u>S. Goldgraben</u>  |  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED 8-13-68                        |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <u>S. Goldgraben, M.D.</u>  |  |  |  |  |   | 22e. ADDRESS <u>VA Hospital, Perry Point, Md.</u>  |   |   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |   |   |                        |  |
|  |  | 8-13-1968  |  | Beverly Cemetery   |   | Beverly Va.  |   |   |                        |  |
| 24. FUNERAL DIRECTOR <u>John W. Lord</u>   |  |  |  |  |   | 25a. RECEIVED BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |                        |  |
| John W. Lord Funeral Director, Elkins, W. Va.  |  |  |  |  |   | AUG 16 1968  |   |   |                        |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11402

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |         |  |        |  |   |  |   |   |          |          |
|--|---------|--|--------|--|---|--|---|---|----------|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  | Middle | Last   | 2a. DATE KNOWN OF DEATH   |  | <input checked="" type="checkbox"/> Month | Day   | Year     | 2b. HOUR |
| MICHELLE   |         |  | E      | LEWIS  | 8-24  |  |   | 1968  | 11:00 PM |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD                  |   | 2d. HOUR |          |
| Female   | Negro   | 7-22-58  |        | 10 YRS.  | MONTHS  | DAYS   | August 24, 1968                           |   | 11:00 PM |          |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |          |          |
| N.Y.   |         | U.S.A.   |        | CECIL  |   |  |   | Md.   |          |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |          |
| Elkton   |         | Union Hospital   |        |  | STUDENT   |  |   | SCHOOL  |          |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?                                       |   | 13e. STREET AND NUMBER  |          |          |
| N.Y.   |         |  |        | N.Y.   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 530 West 152nd Street   |          |          |
| 14. FATHER'S NAME  |         | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME  |  | First                                     | Middle  | Last     |          |
| WILLIE   |         |  |        | LEWIS  | SHIRLEY   |  |   |   | MORRIS   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |   | ADDRESS  |   |   |          |          |
| NO   |         | NONE   |        | WILLIE LEWIS   |   | BRONX, N.Y.  |   |   |          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |        |  |   |  |   |   |          |          |
| PART 1. DEATH WAS CAUSED BY:   |         |  |        |  |   |  |   |   |          |          |
| IMMEDIATE CAUSE (a) Multiple blunt injuries  |         |  |        |  |   |  |   |   |          |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |   |  |   |   |          |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |        |  |   |  |   |   |          |          |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |   |  |   |   |          |          |
| (c)  |         |  |        |  |   |  |   |   |          |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |        |  |   |  |   |   |          |          |
| 8164   |         |  |        |  |   |  |   |   |          |          |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   | 20. AUTOPSY?  |          |          |
|  |         |  |        |  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |   |          |          |
|  |         | 10:30 P.M. 8-24 1968   |        | Passenger in auto-auto collision   |   |  |   |   |          |          |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.   |   | City or Town   |   | County  | State    |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | highway  |        | Intersection #98 and Md.#279   |   | Elkton   |   | Cecil   | Md.      |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |  |   |  |   |   |          |          |
| ACTUAL SIGNATURE   |         | Charles S. Springate   |        |  |   | M.D.   |   | 22b. DATE SIGNED  |          |          |
| EXAMINER'S NAME (Type)   |         | Charles S. Springate, M.D.   |        |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |   | August 25, 1968   |          |          |
|  |         |  |        |  |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |   |          |          |
|  |         |  |        |  |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>               |   |   |          |          |
|  |         |  |        |  |   | ADDRESS (Street, city, town, or county)                        |   |   |          |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)                                   |   | (County)  | (State)  |          |
| BURIAL   |         | 8-31-68  |        | FERN CLIFF   |   | HARTSDALE  |   |   | N.Y.     |          |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |        | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                     |   |   |          |          |
| PIPPIN   |         | FURNERAL HOME  |        | ELKTON MD  |   | DATE AUG 28 1968   |   | Charles Judge   |          |          |

11002

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

| 11395  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                           |  |  |  |  |  |  |  |  |  | 11403   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| First<br><b>FREDERICK</b>  |  |  |  |  |  |  |  |  |  | Middle<br><b>O.</b>   |  |  |  |  |  |  |  |  |  | Last<br><b>LITTLE</b>   |  |  |  |  |  |  |  |  |  | Month<br><b>August</b>  |  |  |  |  |  |  |  |  |  | Day<br><b>6</b>   |  |  |  |  |  |  |  |  |  | Year<br><b>1968</b> |  |  |  |  |  |  |  |  |  | 2:00A                                 |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 3. SEX<br><b>Male</b>  |  |  |  |  |  |  |  |  |  | 4. RACE<br><b>White</b>   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br><b>10/4/18</b>  |  |  |  |  |  |  |  |  |  | 6. AGE (In years<br>last birthday)<br><b>49</b> YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>                         |  |  |  |  |  |  |  |  |  | DAYS<br><b>0</b>    |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> |  |  |  |  |  |  |  |  |  | MIN<br><b>0</b> |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br><b>Cecil County,</b>  |  |  |  |  |  |  |  |  |  | Md.   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Perry Point</b>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VA Hospital</b> |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Pipe Foreman</b>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>----</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br><b>Harford</b>   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br><b>Darlington</b>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER  |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>Oliver Little (D)</b>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Carrie Cooper</b>  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWII</b>                               |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>204-07-5333</b>  |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br><b>VA Hospital Records, Perry Point, Md.</b> |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>185X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>Carcinoma of prostate with metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>6 months</b>                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>177X</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 5</b> , 19 <b>68</b> , to <b>August 6</b> , 19 <b>68</b> . <del>that the deceased</del><br><del>and that in (my) (our) opinion death occurred on the date and hour and from the</del><br><del>causes stated above, (I) (we) (did) (did not) view the body after death.</del>                    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>I. Reus</b>   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><b>August 6, 1968</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>I. REUS, M.D.</b>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br><b>VA Hospital, Perry Point, Maryland</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |  |  |  |  |  |  |  |  | 23b. DATE<br><b>8-9-1968</b>  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harford Memorial Gardens</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Harford Md.</b>                             |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Funeral Home, Rising Sun, Maryland</b>  |  |  |  |  |  |  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 8 1968</b>   |  |  |  |  |  |  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |  |  |  |  |

17403

DEPARTMENT OF DEFENSE

1

August 6, 1968 11:00 AM

10/1/18

USA

VA Hospital

VA Hospital

Oliver (D)

204-07-255 VA Hospital, Fort Point, Me.

2 days

6 months

x

x

August 6, 1968

August 6, 1968

VA Hospital, Fort Point, Maryland

August 6, 1968

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11396

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11404

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Cecil</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Delaware</u> y. COUNTY <u>New Castle</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Elkton</u>  |                                  |   | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Silview Wilmington 19804</u> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Union Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>105 Lindburgh Ave.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Anthony</u> Middle <u>A.</u> Last <u>Maida</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>3</u> Year <u>1968</u>  |   |   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 27, 1898</u>                               |   | 9. AGE (In years lost birthday)<br><u>70</u> yrs.   | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>                 |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Auto Mechanic</u>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Garage</u>                     |   | 11. BIRTHPLACE (State or foreign country)<br><u>Pennsylvania</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |
| 13. FATHER'S NAME<br><u>Domonick Maida</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>No Record</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>222-20-9932</u>   |  | 17. INFORMANT<br><u>Mrs. Alice I. Hanna Maida 105 Lindburg Ave</u>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br><u>4129</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____  |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Years</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>4200</u>   |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <u>Tillman D. Johnson</u> M.D.  |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22. DATE SIGNED <u>8-3-68</u>   |   |
| EXAMINER'S NAME (Type) <u>Tillman D. Johnson M.D.</u>  |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | Address (Street, city, town, or county) <u>103 Singlerly Run Elk</u>                              |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>August 7, 1968</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Silverbrook Cemetery</u>      |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Wilmington Delaware N.C. Co.</u>                                |   |   |
| 24. FUNERAL DIRECTOR<br><u>Ralph E. Hicks</u><br>Hicks Home for Funerals, Elkton, Md.  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>AUG 12 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |

00174



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |                          |  |   |  |  |                        |                        |  |       |
|---|--|--|--------------------------|--|---|--|--|------------------------|------------------------|--|-------|
| 11397   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |  |   | 11405  |  |                        |                        |  |       |
| CERTIFICATE OF DEATH  |  |  |                          |  |   |  |  |                        |                        |  |       |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First                    | Middle   | Lost  | 2a. DATE OF DEATH  |  | 2b. HOUR               |                        |  |       |
| Janice McCann   |  |  |                          | Twin #1  |   | Month 8 Day 9 Year 1968  |  | 12 noon                |                        |  |       |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR        |                        |  |       |
| Female  |  | White  |                          | Aug. 9, 1968   |   | YRS.   |  | MONTHS DAYS HOURS MIN  |                        |  |       |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.                    |                        |  |       |
| Maryland  |  | USA  |                          |  |   | Cecil  |  |                        |                        |  |       |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |                        |  |       |
| Elkton  |  | Union Hospital   |                          | None   |   | None   |  |                        |                        |  |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |                        |  |       |
| Maryland  |  | Cecil  |                          | North East   |   |  |  | R.D. 1                 |                        |  |       |
| 14. FATHER'S NAME   |  |  | First                    | Middle   | Lost  | 15. MOTHER'S MAIDEN NAME   |  |                        | First                  | Middle                                       | Lost  |
| Terry M. McCann   |  |  |                          |  |   | Eleanor Ann Racine   |  |                        |                        |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |  |   | 17. INFORMANT  |  |                        | Address                |  |       |
| None  |  |  | None                     |  |   | Terry M. McCann  |  |                        | R.D. 1 North East, Md. |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |   |  |  |                        |                        | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART I. DEATH WAS CAUSED BY:  |  |  |                          |  |   |  |  |                        |                        |  |       |
| IMMEDIATE CAUSE (a) <u>Fetal immaturity</u>   |  |  |                          |  |   |  |  |                        |                        |  |       |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |   |  |  |                        |                        |  |       |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |                          |  |   |  |  |                        |                        |  |       |
| (b) <u>Very premature delivery</u>  |  |  |                          |  |   |  |  |                        |                        |  |       |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |                          |  |   |  |  |                        |                        |  |       |
| (c)   |  |  |                          |  |   |  |  |                        |                        |  |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |                          |  |   |  |  |                        |                        |  |       |
| <u>776X</u>   |  |  |                          |  |   |  |  |                        |                        |  |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |                        |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                        |                        |  |       |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |                        | County                 |  | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> , 19 <u>68</u> , to <u>8-9</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |   |  |  |                        |                        |  |       |
| 22b. SIGNATURE <u>Jay S. Barnhart Jr.</u> M.D. DEGREE   |  |  |                          |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>8-10-68</u>                                      |                        |                        |  |       |
| 22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.  |  |  |                          |  | 22e. ADDRESS <u>4 Mauldin Ave. North East, Md.</u>  |  |  |                        |                        |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION (City or Town) (County) (State)                        |                        |                        |  |       |
| Burial  |  | 8-12-68  |                          | North East Methodist   |   |  | North East Cecil Md.   |                        |                        |  |       |
| 24. FUNERAL DIRECTOR <u>Paul H. Rouch</u> ADDRESS <u>Box 22 North East, Md.</u>   |  |  |                          |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                      |                        |                        |  |       |
| Grant Funeral Home  |  |  |                          |  | DATE <u>AUG 13 1968</u>   |  |  |                        |                        |  |       |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11398

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11406

|   |  |  |   |   |  |  |   |  |  |  |
|---|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Jeannette McCann</b>   |  |  | 2a. DATE OF DEATH<br><b>8</b> Month <b>9</b> Day <b>1968</b>  |   |  | 2b. HOUR<br><b>12 noon</b>   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Aug. 9, 1968</b>   |  | 6. AGE (In years lost birthday)<br><b>—</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Cecil</b>   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Elkton</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Union Hospital</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Cecil</b>   |   | 13c. CITY OR TOWN<br><b>North East</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>R.D. 1</b>          |  |
| 14. FATHER'S NAME<br><b>Terry M. McCann</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Eleanor Ann Racine</b>   |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT<br><b>Terry M. McCann</b>  |  |   | Address <b>R.D. 1 North East, Md.</b>                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fetal immaturity</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Very premature delivery</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>776x</b>  |  |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>68</b> , to <b>8-9</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>8-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.       |  |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Barnhart Jr.</b>   |  |  |   | 22c. DATE SIGNED<br><b>8-10-68</b>  |  |  |   | 22d. PHYSICIAN'S NAME (Type)<br><b>Jay S. Barnhart Jr.</b>       |  |  |
| 22e. ADDRESS<br><b>4 Mauldin Ave.</b>   |  |  |   | 22f. ADDRESS<br><b>North East, Md.</b>  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8-12-68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>North East Methodist</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>North East Cecil Md.</b>                           |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Grant Funeral Home</b>   |  |  |   | ADDRESS Box 22<br><b>North East, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 13 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>               |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |                            |  |
|--|--|--|--|---|---|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |                            |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |                            | 2b. HOUR                                     |
| John   |  |  | McCraw   |   |   | Month Day Year<br>August 27, 1968   |  |                            | 0:45 AM                                      |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)                                      |                            | IF UNDER 1 YEAR                              |
| Male   |  | White  |  | May 21, 1890  |   |   | 78 YRS.  |                            | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH   |                            |  |
| Virginia   |  | U.S.A.   |  |   |   |   | Cecil Md.  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                            | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Elkton   |  |  | Union Hospital   |   |   | Laborer   |  |                            | Schult Corp                                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET AND NUMBER   |                            |  |
| Maryland   |  |  | Cecil  |   | Elkton  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 127 E. High St.  |                            |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |                            |  |
| First Middle Last<br>Alex McCraw   |  |  | First Middle Last<br>----- Easter  |   |   |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |                            |  |
| No   |  |  | 220-12-7549  |   | Mrs. Lucy J. McCraw, Elkton, Md.  |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u><br><u>5990</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>JANUARY TRACT INFECTION</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |  |                            |  |
| <u>609X CEREBRAL ARTERIO SCLEROSIS</u>   |  |  |  |   |   |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                            |  |
|  |  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                        |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                            |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |                            |  |
|  |  |  |  |   |   |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>68</u> , to <u>AUG 27, 1968</u> , that (I) ( <input checked="" type="checkbox"/> ) saw the deceased alive on <u>8/26/68</u> , 19 <u>68</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) ( <input type="checkbox"/> ) did not view the body after death. |  |  |  |   |   |   |  |                            |  |
| 22b. SIGNATURE<br><u>Robert L. Gray</u>  |  |  |  |   | DEGREE  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br>9/10/68  |                            |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Robert L. Gray   |  |  |  |   | 22e. ADDRESS<br>123 W. High Street, Elkton, Md.                                 |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |                            |  |
| Burial   |  | 8/29/68  |  | Cherry Hill Meth. Cem.  |   | Cherry Hill, Md.  |  |                            |  |
| 24. FUNERAL DIRECTOR<br><u>Ralph E. Hicks</u>  |  |  |  |   | ADDRESS   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |  |
| Hicks Home for Funerals, Elkton, Md.   |  |  |  |   | DATE  |   | SEP 16 1968  |                            | <u>Charles Judge</u>                         |

10421

RECEIVED

10421



11400

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11408

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |         |  |        |  |                          |  |                  |  |                          |  |
|---|---------|--|--------|--|--------------------------|--|------------------|--|--------------------------|--|
| 1. DECEASED-NAME (Type or Print)  |         | First  | Middle | Last   | 2a. DATE KNOWN OF DEATH  |  | Month            | Day  | Year                     | 2b. HOUR                                     |
| Asher Hudson Melson   |         |  |        |  | 8-13                     |  | 8                | 13   | 1968                     | 7:45 AM                                      |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR          |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD |  |
| M   | W       | 4-6-52   |        | 86 YRS.  | MONTHS DAYS              |  | HOURS MIN.       |  | 8-13 Year 1968 9 A.M.    |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH   |                  |  |                          |  |
| Del.  |         | U.S.A.   |        | Cecil  |                          |  |                  |  | Md.                      |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |  |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |                  | 12b. KIND OF BUSINESS OR INDUSTRY  |                          |  |
| Elkton  |         | Union Hosp. (D.O.A.)   |        |  |                          | Marine Engineer (Ret.)   |                  | Marine   |                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  | 13e. STREET AND NUMBER   |                          |  |
| Md.   |         | Cecil  |        | Earleville   |                          |  |                  | P.O. Box 33, 40 Del. Ave.  |                          |  |
| 14. FATHER'S NAME   |         | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |  | First            | Middle   | Last                     |  |
| Capt. William   |         |  |        | Melson   | Emmaline                 |  |                  |  | Burton                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | (If yes give war or dates of service)  |        | 16b. SOCIAL SECURITY NO.   |                          | 17. INFORMANT ADDRESS  |                  |  |                          |  |
| No  |         |  |        | 76-03-9548   |                          | Mrs. Viola Wilson, Earleville, Md.   |                  |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |  |                          |  |                  |  |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>   |         |  |        |  |                          |  |                  |  |                          | <u>Unk</u>                                   |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |                          |  |                  |  |                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |                          |  |                  |  |                          |  |
| (c)   |         |  |        |  |                          |  |                  |  |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |        |  |                          |  |                  |  |                          |  |
| 4221 <u>Diabetes mellitus</u>   |         |  |        |  |                          |  |                  |  |                          |  |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                          |  |                  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |        | 21b. TIME OF INJURY Month, Day, Year   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |                  |  |                          |  |
|   |         |  |        | HOUR A.M. P.M. 19  |                          |  |                  |  |                          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.   |                          | City or Town   |                  | County   |                          | State  |
|   |         |  |        |  |                          |  |                  |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |        |  |                          |  |                  |  |                          |  |
| ACTUAL SIGNATURE  |         | John M. Byers, M.D.  |        |  |                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                  | 22b. DATE SIGNED   |                          |  |
| EXAMINER'S NAME (Type)  |         | John M. Byers, Md.   |        |  |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                  | 8-13-68  |                          |  |
|   |         |  |        |  |                          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |                  | Elkton, Md.  |                          |  |
|   |         |  |        |  |                          | ADDRESS (Street, city, town, or county)  |                  |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (City or Town) (County) (State)  |                  |  |                          |  |
| Burial  |         | Aug. 16, 1968  |        | Edgewood Memorial Park   |                          | Media Pa.  |                  |  |                          |  |
| 24. FUNERAL DIRECTOR  |         |  |        | ADDRESS  |                          | 25a. REC'D BY REGISTRAR  |                  | 25b. REGISTRAR'S SIGNATURE   |                          |  |
| Edward Fellows & Son.   |         |  |        | Millington, Md. 21651  |                          | DATE AUG 16 1968   |                  | Charles Judge  |                          |  |







1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

11401

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11409

## CERTIFICATE OF DEATH

|  |                         |   |   |   |  |
|--|-------------------------|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>ARCHIE L. MOORE</b>  |                         |   | 2a. DATE OF DEATH<br>Month <b>8</b> Day <b>15</b> Year <b>68</b>  |   | 2b. HOUR<br><b>9:30p</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br><b>1-5-16</b>   |   | 6. AGE (In years<br>last birthday)<br><b>52</b> YRS.                               |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Cecil</b> Md  |
| 10. CITY OR TOWN OF DEATH<br><b>Perry Point</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Veterans Administration</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Silk twister</b> |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Cecil</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   | 13e. STREET AND NUMBER<br><b>Poles Road</b>  |
| 14. FATHER'S NAME<br>First <b>Charles J.</b> Middle <b>Moore</b> Last <b>(D)</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>First <b>Rose</b> Middle <b>Unk.</b> Last <b>(D)</b>                                  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give year or date of service)<br><b>WW II</b>                                 |   | 17. INFORMANT<br>Address<br><b>VA Hospital Records, Perry Point, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>inactive tuberculosis</b><br>(b) <b>Extensive pulmonary fibrosis assoc/w healed</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>019.0<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>002.2 |                         |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3-7 days</b><br><b>years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>Sclerosis of coronary arteries, moderate</b>  |                         |   |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 67   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that <b>VA</b> (this hospital) attended the deceased from <b>May 16</b> , 19 <b>67</b> , to <b>Aug. 15</b> , 19 <b>68</b> <del>xxxxxxx</del><br><del>xxxxxxx</del> and that in (my) (aur) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |   |   |   |  |
| 22b. SIGNATURE<br><b>A. L. Mooney M.D.</b>   |                         |   |   | 22c. DATE SIGNED<br><b>8-16-68</b>  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>A. L. MOONEY, M.D.</b>   |                         |   |   | 22e. ADDRESS<br><b>VA Hospital, Perry Point, Md.</b>  |  |
| 23a. BURIAL, CREMATION<br>REMOVAL (Specify)  |                         | 23b. DATE<br><b>8/20/1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balto National Cem. Baltimore Md</b>                                     |  |
| 24. FUNERAL DIRECTOR<br><b>Pennington &amp; Son Funeral Home, Havre de Grace, Md</b>   |                         | ADDRESS<br><b>Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 2-1 1968</b>  |  |
|  |                         |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

11508

STATE OF OHIO

NOON

1.1

1-3-10

white

hair

Gold

USN

Maryland

skin cancer

Veterans Administration

Forty Point

John Wood

Richmond

Maryland

Wm. (D)

Ross

Moore (A)

Charles J.

114-07-091 VA Hospital Records, Forty Point, Md.

Wm. II

10

3-7 days

monopneumonia, bilateral

infective endocarditis

extensive pulmonary fibrosis scars, healed

solitary of category affected, moderate

XI

00 XXXXXXXX

Aug. 12

87

May 18

XXXXXXXXXXXXXXXXXXXX

8-10-68

VA Hospital, Forty Point, Md.

A. A. MOORE, M.D.

Maryland

For General Home, Navy de Grace, Aug 2-1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11403  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                       |  |  |  |  |  |  |  |  |  | 11410   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Lillian M. Owens  |  |  |  |  |  |  |  |  |  | 8 Month 19 Year 1968  |  |  |  |  |  |  |  |  |  | 8:P:M   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  |  |  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>12/5/78   |  |  |  |  |  |  |  |  |  | 6. AGE (In years<br>lost birthday)<br>89 YRS.   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN      |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Cecil   |  |  |  |  |  |  |  |  |  | Md.   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Elkton  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Union Hospital |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>HOME  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Cecil  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Elkton   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>15 Joseph Gallagher |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>James Scott  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Addie OWENS                                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER<br>Yes, no, or unknown) IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br>No  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-54-2145   |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>William C. Owens (Son)   |  |  |  |  |  |  |  |  |  | Address<br>Same   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Shutdown Nephritis</u><br>4369<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fractured Hip</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>3-Days<br>3-Weeks<br>3-Weeks                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS<br>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>331X   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/27/1968, to 8/15/1968, that (I) (we) last<br>saw the deceased alive on 8/15/1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br>James L. Johnson M.D.   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br>8/16/68   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>James L. Johnson M.D.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>245 East High St., Elkton Cecil Md.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>8-17-68  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEAD OF CHRISTIANA  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>NEWARK CASTLE DEL                              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Robert Ford<br>PIPPIN FUNERAL HOME ELKTON, MD  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>AUG 19 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                               |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1514  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |  |  |   |  |                   |
|--|--|--|--------------------------|---|--|--|---|--|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |  |  |   |  |                   |
| CERTIFICATE OF DEATH   |  |  |                          |   |  |  |   |  |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle  | Last   | 2a. DATE OF DEATH<br>Month Day Year  |   | 2b. HOUR                                     |                   |
| Wilamina   |  |  | P.                       |   | Redding  | August, 26, 1968   |   | 5 A.M.                                       |                   |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |  | 6. AGE (in years last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS               |                   |
| Female   |  | White  |                          | November, 8, 1875   |  | 92   |   |  |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   |  |                   |
| Md.  |  | U.S.A.   |                          |   |  | Cecil  |   |  |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |                   |
| Elkton   |  | Devine Nursing Home.   |                          | Housework   |  | Home   |   |  |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                       |                   |
| Md.  |  | Cecil  |                          | Fredricktown  |  |  |   | ---  |                   |
| 14. FATHER'S NAME  |  |  | First                    | Middle  | Last   | 15. MOTHER'S MAIDEN NAME   |   |  | First Middle Last |
| William  |  |  | B.                       |   | Price  | Elizabeth  |   |  | Watts.            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No.   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address                                    |  |   |  |                   |
|  |  |  | 221-32-8111              |   | James Richard Redding, Georgetown, Md. 21930             |  |   |  |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |                          |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Nephrosclerosis</b>   |  |  |                          |   |  |  |   |  |                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |  |  |   |  |                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>446X</b>   |  |  |                          |   |  |  |   |  |                   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |                          |   |  |  |   |  |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                          |   |  |  |   |  |                   |
| <b>Enemia severe. Thrombocytopenia</b>   |  |  |                          |   |  |  |   |  |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                   |
|  |  |  |                          |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |                   |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19  |                          |   |  |  |   |  |                   |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |                   |
| While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |                          |   |  |  |   |  |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 Aug</u> , 19 <u>68</u> , to <u>26 Aug</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>26 Aug</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |                          |   |  |  |   |  |                   |
| 22b. SIGNATURE   |  |  |                          |   | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED  |
| <u>Wallace Obenshain M.D.</u>  |  |  |                          |   |  |  |   |  | <u>27 Aug 68</u>  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |                          |   | 22e. ADDRESS   |  |   |  |                   |
| Wallace Obenshain, M.D.  |  |  |                          |   | Cecilton, Md. 21913                                      |  |   |  |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |  |                   |
| Burial   |  | Aug. 28, 1968  |                          | Galena Cemetery   |  | Galena, Kent Md.   |   |  |                   |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |                          |   | 25a. REC'D BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE  |  |                   |
| Edward Fellows & Son, Millington, Md. 21651  |  |  |                          |   | DATE AUG 29 1968   |  | <u>Charles Judge</u>  |  |                   |

11111

UNITED STATES OF AMERICA

30, 1988 3 3

November 1, 1875

Good

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

|  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 11404  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 11412  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Carl Wesley Rexrode  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>August 25, 1968   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>3:45 PM  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>NOV 30, 1917  |  |  |  |  | 6. AGE (In years last birthday)<br>50 YRS.  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Cecil Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Perry Point   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VA Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Carpenter  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Builder  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  |  | 13c. CITY OR TOWN<br>Catonsville  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>57 N. Prospect Avenue            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Emory J. Rexrode  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ada May Moats                                 |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Yes  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>223-18-8094   |  |  |  |  | 17. INFORMANT Address<br>Records at VA Hospital, Perry Point, Md.   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>746.4 DUE TO, OR AS A CONSEQUENCE OF <u>w/multiple large defects of foramen ovale</u><br>(b) <u>Congenital heart disease (atrial septal defect)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2-3 days<br>3-4 yrs   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)<br>7543   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br>VA          |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>December 14, 1965</u> , to <u>August 25, 1968</u> , <u>XXXXXX</u><br><u>XXXXXX</u> and that in <u>last</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>XX</u> (we) (did) <u>(did not)</u> view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>A. L. MOONEY, M.D.   |  |  |  |  | DEGREE<br>M.D.  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  |  |  | 22c. DATE SIGNED<br>8-26-68   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>A. L. MOONEY, M.D.   |  |  |  |  | 22e. ADDRESS<br>VA HOSPITAL, Perry Point, Md.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>8/28/1968  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Cemetery   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Glen Burnie, A.A. Co. Ind.                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Cowan & Sons Inc. 901 Hollins St.  |  |  |  |  |   |  |  |  |  | 24b. REC'D BY REGISTRAR<br>DATE AUG 28 1968   |  |  |  |  |   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                |  |  |  |  |  |  |  |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| MIDDLE STATE DEPARTMENT OF HEALTH   |  |                             |  |  |  |  |  |   |  |   |  |
|---|--|-----------------------------|--|--|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                             |  |  |  |  |  |   |  |   |  |
| 11405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11413   |  |                             |  |  |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>o. COUNTY <u>CECIL</u> MARYLAND  |  |                             |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>                                       |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>   |  |                             |  |  |  | c. LENGTH OF STAY IN 1b <u>20 YEARS</u>  |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |                             |  |  |  | d. STREET ADDRESS  |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>EURIE MARGARET RHOADES</u>   |  |                             |  |  |  | 4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1968</u>  |  |   |  |   |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>Col</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>FEB 24-1909</u>  |  | 9. AGE (In years lost birthday) <u>59</u> yrs.  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MUNITIONS SHELLLOADING</u>   |  |                             |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  |   |  |   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY   |  |                             |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |   |  |   |  |
| 13. FATHER'S NAME <u>JOHN A. WEBSTER</u>  |  |                             |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARY HARDMAN</u>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |                             |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <u>CLARENCE RHOADES</u> Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109 CORONARY HEART DYSRHYTHMIA</u><br>DUE TO (b) <u>CHRONIC CORONARY DISEASE</u><br>DUE TO (c) <u>SEVERAL YEARS</u>  |  |                             |  |  |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)  |  |                             |  |  |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>4120-1</u>  |  |                             |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL FROM CHAIR AT HOME</u>  |  |   |  |   |  |
| 20c. TIME OF INJURY Month <u>Jan</u> Day <u>30</u> Year <u>1968</u> Hour <u>9:30</u> a.m. <u>9:30</u> p.m.  |  |                             |  |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AT HOME</u> |  | 20f. RURAL <input type="checkbox"/> (County) <u>CECIL</u> (State) <u>MD</u> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                             |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>Henry U. Davis</u> M.D.   |  |                             |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
| EXAMINER'S NAME (Type) <u>HENRY U. DAVIS</u>  |  |                             |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |                             |  |  |  | 23b. DATE THEREOF <u>9/4/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Bohemia Manor Cem.</u>                          |  | 23d. LOCATION (City or town) (County) (State) <u>Bohemia Manor Md.</u>      |  |
| 24. FUNERAL DIRECTOR <u>Coluk Bell</u> ADDRESS <u>909 Poplar St.</u>  |  |                             |  |  |  | 25a. REC'D BY REGISTRAR <u>SEP 4 1968</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                                       |  |   |  |

1113

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## CERTIFICATE OF DEATH

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>William T. Rothwell</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>August</b> Day <b>28</b> Year <b>1968</b> |   |  | 2b. HOUR <b>10</b> MIN <b>AM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br><b>July 26, 1894</b>  |  | 6. AGE (In years last birthday)<br><b>74</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Cecil</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Elkton</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Union Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Paper Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Elk Paper Mfg</b>                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Cecil</b>   |   | 13c. CITY OR TOWN<br><b>Elkton</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br><b>William T. Rothwell</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Rachel Ann Pearson</b>                               |   | 13e. STREET AND NUMBER<br><b>R.D. (Andora)</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>Mrs. Mabel D. Rothwell, Elkton, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>4339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>332X</b><br>(b) <b>Arteriosclerosis of cerebral vessels</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Arteriosclerotic heart disease</b>   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                     |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1968</b> , to <b>Aug. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Edgar E. Folk, M.D.</b> DEGREE   |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>9/9/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Edgar E. Folk, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>Newark, Delaware</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>8/30/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cherry Hill Meth. Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cherry Hill, Md.</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Ralph E. Hicks</b><br><b>Hicks Home for Funerals, Elkton, Md.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>SEP 16 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-68

| 11407   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 11415  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Harry   |  |  |  |  |  |  |  |  |  | Lea  |  |  |  |  |  |  |  |  |  | Shaw   |  |  |  |  |  |  |  |  |  | August, 13, 1968   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | January 25, 1888   |  |  |  |  |  |  |  |  |  | 80   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Cecil  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Elkton  |  |  |  |  |  |  |  |  |  | Union Hospital   |  |  |  |  |  |  |  |  |  | Laborer  |  |  |  |  |  |  |  |  |  | Construction   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | Kent   |  |  |  |  |  |  |  |  |  | Galena   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| James David Shaw  |  |  |  |  |  |  |  |  |  | Anna   |  |  |  |  |  |  |  |  |  | Reese  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Yes.  |  |  |  |  |  |  |  |  |  | W.W. 1   |  |  |  |  |  |  |  |  |  | 220-03-0465  |  |  |  |  |  |  |  |  |  | Mrs. Mary Hester Shaw,   |  |  |  |  |  |  |  |  |  | Galena, Md. 21635           |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | PART 1: DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4129  |  |  |  |  |  |  |  |  |  | Arteriosclerotic Heart Disease.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | SIX MOS  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 4200  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  | Poss pulmonary Embolism  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | City or Town County State  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 11 Aug 68 12 Aug 68  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 Aug 68, 19, to 12 Aug 68, 19, that (I) (we) last saw the deceased alive on 13 August 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Wallace Obenshain   |  |  |  |  |  |  |  |  |  | 15 Aug 68  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Wallace Obenshain, M.D.   |  |  |  |  |  |  |  |  |  | Cecilton, Md. 21913  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | Aug. 17, 1968  |  |  |  |  |  |  |  |  |  | Galena Cemetery  |  |  |  |  |  |  |  |  |  | Galena, Kent Md.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Edward Fellows & Son,   |  |  |  |  |  |  |  |  |  | Millington, Md. 21651  |  |  |  |  |  |  |  |  |  | AUG 20 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

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1980-1981, 1981-1982, 1982-1983, 1983-1984, 1984-1985, 1985-1986, 1986-1987, 1987-1988, 1988-1989, 1989-1990, 1990-1991, 1991-1992, 1992-1993, 1993-1994, 1994-1995, 1995-1996, 1996-1997, 1997-1998, 1998-1999, 1999-2000, 2000-2001, 2001-2002, 2002-2003, 2003-2004, 2004-2005, 2005-2006, 2006-2007, 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, 2013-2014, 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020, 2020-2021, 2021-2022, 2022-2023, 2023-2024, 2024-2025, 2025-2026, 2026-2027, 2027-2028, 2028-2029, 2029-2030, 2030-2031, 2031-2032, 2032-2033, 2033-2034, 2034-2035, 2035-2036, 2036-2037, 2037-2038, 2038-2039, 2039-2040, 2040-2041, 2041-2042, 2042-2043, 2043-2044, 2044-2045, 2045-2046, 2046-2047, 2047-2048, 2048-2049, 2049-2050, 2050-2051, 2051-2052, 2052-2053, 2053-2054, 2054-2055, 2055-2056, 2056-2057, 2057-2058, 2058-2059, 2059-2060, 2060-2061, 2061-2062, 2062-2063, 2063-2064, 2064-2065, 2065-2066, 2066-2067, 2067-2068, 2068-2069, 2069-2070, 2070-2071, 2071-2072, 2072-2073, 2073-2074, 2074-2075, 2075-2076, 2076-2077, 2077-2078, 2078-2079, 2079-2080, 2080-2081, 2081-2082, 2082-2083, 2083-2084, 2084-2085, 2085-2086, 2086-2087, 2087-2088, 2088-2089, 2089-2090, 2090-2091, 2091-2092, 2092-2093, 2093-2094, 2094-2095, 2095-2096, 2096-2097, 2097-2098, 2098-2099, 2099-2100, 2100-2101, 2101-2102, 2102-2103, 2103-2104, 2104-2105, 2105-2106, 2106-2107, 2107-2108, 2108-2109, 2109-2110, 2110-2111, 2111-2112, 2112-2113, 2113-2114, 2114-2115, 2115-2116, 2116-2117, 2117-2118, 2118-2119, 2119-2120, 2120-2121, 2121-2122, 2122-2123, 2123-2124, 2124-2125, 2125-2126, 2126-2127, 2127-2128, 2128-2129, 2129-2130, 2130-2131, 2131-2132, 2132-2133, 2133-2134, 2134-2135, 2135-2136, 2136-2137, 2137-2138, 2138-2139, 2139-2140, 2140-2141, 2141-2142, 2142-2143, 2143-2144, 2144-2145, 2145-2146, 2146-2147, 2147-2148, 2148-2149, 2149-2150, 2150-2151, 2151-2152, 2152-2153, 2153-2154, 2154-2155, 2155-2156, 2156-2157, 2157-2158, 2158-2159, 2159-2160, 2160-2161, 2161-2162, 2162-2163, 2163-2164, 2164-2165, 2165-2166, 2166-2167, 2167-2168, 2168-2169, 2169-2170, 2170-2171, 2171-2172, 2172-2173, 2173-2174, 2174-2175, 2175-2176, 2176-2177, 2177-2178, 2178-2179, 2179-2180, 2180-2181, 2181-2182, 2182-2183, 2183-2184, 2184-2185, 2185-2186, 2186-2187, 2187-2188, 2188-2189, 2189-2190, 2190-2191, 2191-2192, 2192-2193, 2193-2194, 2194-2195, 2195-2196, 2196-2197, 2197-2198, 2198-2199, 2199-2200, 2200-2201, 2201-2202, 2202-2203, 2203-2204, 2204-2205, 2205-2206, 2206-2207, 2207-2208, 2208-2209, 2209-2210, 2210-2211, 2211-2212, 2212-2213, 2213-2214, 2214-2215, 2215-2216, 2216-2217, 2217-2218, 2218-2219, 2219-2220, 2220-2221, 2221-2222, 2222-2223, 2223-2224, 2224-2225, 2225-2226, 2226-2227, 2227-2228, 2228-2229, 2229-2230, 2230-2231, 2231-2232, 2232-2233, 2233-2234, 2234-2235, 2235-2236, 2236-2237, 2237-2238, 2238-2239, 2239-2240, 2240-2241, 2241-2242, 2242-2243, 2243-2244, 2244-2245, 2245-2246, 2246-2247, 2247-2248, 2248-2249, 2249-2250, 2250-2251, 2251-2252, 2252-2253, 2253-2254, 2254-2255, 2255-2256, 2256-2257, 2257-2258, 2258-2259, 2259-2260, 2260-2261, 2261-2262, 2262-2263, 2263-2264, 2264-2265, 2265-2266, 2266-2267, 2267-2268, 2268-2269, 2269-2270, 2270-2271, 2271-2272, 2272-2273, 2273-2274, 2274-2275, 2275-2276, 2276-2277, 2277-2278, 2278-2279, 2279-2280, 2280-2281, 2281-2282, 2282-2283, 2283-2284, 2284-2285, 2285-2286, 2286-2287, 2287-2288, 2288-2289, 2289-2290, 2290-2291, 2291-2292, 2292-2293, 2293-2294, 2294-2295, 2295-2296, 2296-2297, 2297-2298, 2298-2299, 2299-2300, 2300-2301, 2301-2302, 2302-2303, 2303-2304, 2304-2305, 2305-2306, 2306-2307, 2307-2308, 2308-2309, 2309-2310, 2310-2311, 2311-2312, 2312-2313, 2313-2314, 2314-2315, 2315-2316, 2316-2317, 2317-2318, 2318-2319, 2319-2320, 2320-2321, 2321-2322, 2322-2323, 2323-2324, 2324-2325, 2325-2326, 2326-2327, 2327-2328, 2328-2329, 2329-2330, 2330-2331, 2331-2332, 2332-2333, 2333-2334, 2334-2335, 2335-2336, 2336-2337, 2337-2338, 2338-2339, 2339-2340, 2340-2341, 2341-2342, 2342-2343, 2343-2344, 2344-2345, 2345-2346, 2346-2347, 2347-2348, 2348-2349, 2349-2350, 2350-2351, 2351-2352, 23

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• **Check for updates** – This article has been checked for updates by the publisher.

1995 - 94 online

John E. Bailey

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Table 1. Continued

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|--|-----------------------|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 11408   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 11416   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><i>Charles</i>  |  |  | Middle<br><i>B.</i>   |  |  | Last<br><i>Simpers</i>  |   |  | 2a. DATE OF DEATH<br>Month<br><i>Aug</i> Day<br><i>26</i> , Year<br><i>1968</i> |  |  | 2b. HOUR<br><i>M</i>  |  |  |  |  |  |  |
| 3. SEX<br><i>Male</i>   |  |  | 4. RACE<br><i>Can</i>  |  |  | 5. DATE OF BIRTH<br><i>July 15, 1909</i>  |  |  | 6. AGE (In years<br>lost birthday)<br><i>59</i> YRS.  |   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.                              |  |  | IF UNDER 24 HRS.      |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><i>Maryland</i>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Cecil</i>  |   |  | Md.   |  |  |                       |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Perryville</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><i>Patterson Ave.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><i>Retired</i>  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><i>A.P.G.</i>   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><i>Florida</i>  |  |  | 13b. COUNTY<br><i>Hallandale</i>   |  |  | 13c. CITY OR TOWN<br><i>Hallandale</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><i>1000 S.W. 10th Terr. Apt 9</i>                     |  |  |                       |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First<br><i>Harry</i>  |  |  | Middle<br><i>H.</i>  |  |  | Last<br><i>Simpers</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><i>Teresa</i>  |   |  | Middle<br><i>E</i>  |  |  | Last<br><i>Bayard</i> |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><i>Yes</i>   |  |  | (If yes give war or dates of service)<br><i>WW II</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>214-20-2842</i>  |  |  | 17. INFORMANT<br><i>Allen H. Simpans, Per. T. Depost, Ind</i>                                   |   |  | Address   |  |  |                       |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Heart Failure</i><br><i>428X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(b) <i>Chronic Myocarditis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Arteriosclerosis</i> |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |   |  |  |                       |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>4221</i><br><i>Diabetes</i>   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |  |   |  |  |                       |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased <i>Aug 26 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Clarence I. Benson M.D.</i>  |  |  | 22c. DATE SIGNED<br><i>Aug 26-68</i>   |  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br><i>Clarence I. Benson M.D.</i>   |  |  | 22e. ADDRESS<br><i>Per. Depart. Md</i>  |   |  |   |  |  |                       |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>Aug. 29, 1968</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Methodist North East Md. Cemetery Cecil Maryland.</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)   |   |  |   |  |  |                       |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Lee A. Patterson &amp; Son, Perryville, Md.</i>  |  |  | 25a. REC'D BY REGISTRAR<br><i>SEP 3 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Clarence I. Benson</i>   |  |  |   |   |  |   |  |  |                       |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

| 11403  |  |  |  |  |   |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 11417  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  |   |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |   |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Roy Middle STRAIGHT Lost   |  |  |  |  |   |  |  |  |  | Month August Day 20, Year 1968  |  |  |  |  |   |  |  |  |  | 3:00p M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>White  |  |  |  |  | 5. DATE OF BIRTH<br>8-5-98  |  |  |  |  | 6. AGE (In years last birthday)<br>70 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>West Va.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Cecil County Md.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Perry Point   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VA Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Salesman   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>West Va.  |  |  |  |  | 13b. COUNTY<br>Fairmont   |  |  |  |  | 13c. CITY OR TOWN<br>Fairmont   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>712 Locust St.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First William Middle Emery Lost Straight  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Margaret Middle Ice Lost                                  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) Yes WW I  |  |  |  |  |   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217 54 83 82   |  |  |  |  | 17. INFORMANT<br>Address VA Hospital Records - Perry Point, Maryland |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis</u><br>4379<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Melena, cause undetermined</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>lost.</u> |  |  |  |  |   |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>-<br>6 Mo.                                      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>334X   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>6-15-67</u> , 19 <u>67</u> , to <u>8-20-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>SEYMOUR GOLDGRABEN, M.D.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | DEGREE<br>ATTENDING PHYS.   |  |  |  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>SEYMOUR GOLDGRABEN, M.D.   |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>VA Hospital - Perry Point, Maryland   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |  |  |  |  | 23b. DATE<br>Aug. 21, 1968  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baptist Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Barracksville, West Va.                        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>FREY FUNERAL HOME-Madison St., Fairmont, W. Va.  |  |  |  |  |   |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>AUG 27 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                          |  |  |  |  |  |  |  |  |  |



## INDEX

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|--|--|--|--|--|-------------------------------|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                               |   |  |                                   |  |
| CERTIFICATE OF DEATH   |  |  |  |  |                               |   |  |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |                               | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |
| Kimberly Ann Strickler   |  |  |  |  |                               | Aug. 18 Day 1968  |  | 5:20 P                            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                               | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |
| Female   |  | White  |  | Aug. 18, 1968  |                               | YRS.  |  | 9 50                              |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. COUNTY OF DEATH  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Md.  |  | USA  |  |  |                               | Cecil   |  | Md.                               |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                               | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Elkton   |  |  | Union Hospital   |  |                               | ---   |  | ---                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. CITY OR TOWN  |  |                               | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER            |  |
| Penna. ---   |  |  | Chester  |  |                               | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |  | ---                               |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |                               |   |  |                                   |  |
| Eric J. Strickler  |  |  | Sue Reynolds   |  |                               |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address         |   |  |                                   |  |
|  |  |  | ----   |  | Eric Strickler, Delta, Penna. |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prenatal aspiration of bloody amniotic fluid.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Fetal distress.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Abruptio placenta.</u> |  |  |  |  |                               |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |                               |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |                                   |  |
|  |  |  |  |  |                               |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                               |   |  |                                   |  |
|  |  |  |  |  |                               |   |  |                                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |                               | City or Town  |  | County State                      |  |
|  |  |  |  |  |                               |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |  |                               |   |  |                                   |  |
| 22b. SIGNATURE <u>Jay S. Barnhart M.D.</u>   |  |  |  | 22c. DATE SIGNED   |                               | Aug. 19, 1968   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart M.D.  |  |  |  | 22e. ADDRESS   |                               | Elkton, Md.   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                               | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |
| Burial   |  | Aug. 20, 1968  |  | Slate Ridge  |                               | Delta, York, Penna.   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR DATE   |                               | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |
| John H. Harkins, Delta, Penna.   |  |  |  | AUG 23 1968  |                               | Charles Judge   |  |                                   |  |

11618

UNITED STATES

11618

Kindly and respectfully

Aug. 18, 1908

Dear Sir,

Dear Sir,

Dear Sir,

Very respectfully,  
Your obedient servant,  
J. B. [Signature]

Very respectfully,  
Your obedient servant,  
J. B. [Signature]

J. B. [Signature]

Aug. 18, 1908

Very respectfully,  
Your obedient servant,  
J. B. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers at pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11411

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 Film G403 5/12/68  
**CERTIFICATE OF DEATH**

11419

|   |  |  |   |  |   |  |  |  |  |  |
|---|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><i>Edward A. Washington</i>   |  |  | 2a. DATE OF DEATH Month Day Year<br><i>Aug. 3 1968</i>  |  |   | 2b. HOUR<br><i>9 P. M.</i>   |  |  |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Negro</i>  |   | 5. DATE OF BIRTH<br><i>October 15, 1886</i>  |   | 6. AGE in years last birthday<br><i>81 8 1/2</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.        |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                              |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Cecil</i> Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Elkton</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><i>Devine Rest Home</i> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Farmer</i> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Farmer</i>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  |  | 13b. COUNTY<br><i>Harford</i>   |  | 13c. CITY OR TOWN<br><i>Harford</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>427 Race Track Road</i> |  |
| 14. FATHER'S NAME First Middle Last<br><i>John Washington</i>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Jeannette Bowser</i>                                   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><i>No</i>   |  |  | 16b. SOCIAL SECURITY NO.<br><i>212-30-6943</i>  |  | 17. INFORMANT Address<br><i>Mrs. Walter Garrison Hyannis, Mass.</i>               |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ASHD with cardiac decompensation</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4200</i><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Gelitis; chronic renal disease</i> |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Unknown</i> |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 26, 1968</i> , to <i>August 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>August 3, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>S. Ralph Andrews, Jr., M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |  | 22c. DATE SIGNED<br><i>8-3-68</i>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>S. RALPH ANDREWS JR.</i>   |  |  |   |  | 22e. ADDRESS<br><i>233 E. MAIN ST., ELKTON, MARYLAND</i>                          |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>Aug. 7, 1968</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Asbury Methodist Cem.</i>   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Churchville, Harford, Md.</i>                        |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>Orlinda J. Bullock, Harford, Md.</i>   |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <i>AUG 8 1968</i>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Young</i>   |  |  |  |

11319

RECEIVED

11319

1970 and 1971

1970 and 1971

1970 and 1971

1970 and 1971

1970 and 1971

1970 and 1971

1970 and 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |   |  |  |
|---|--|---|--|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |   |  |  |
| 11412 Item 5 Film 6403 8/10/68 11420  |  |   |  |   |  |   |   |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Lena Wasylczuk</b>  |  |   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>Aug. 4 68</b>  |   |   | 2b. HOUR<br><b>9:20</b>                                      |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>1-14-1897</b>  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Austria Hungary</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Cecil</b> Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Elkton</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Union Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>                            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>                         |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Cecil</b>   |  | 13c. CITY OR TOWN<br><b>Chesapeake City</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                                       |  |
| 14. FATHER'S NAME First Middle Last<br><b>Demytriv Slobogin</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary ?</b>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT Address<br><b>MARY HRABEC-CHESAPEAKE CITY, MD</b>   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>Ruptured Myocardial Infarction</b> |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Years</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-31-</b> 19 <b>68</b> , to <b>8-4-</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-4-</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Wallace Obenshain</b>  |  |   |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>8-6-68</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Wallace Obenshain</b>  |  |   |  |   | 22e. ADDRESS<br><b>Cecilton, Maryland</b>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>8-7-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST ROSE OF LIMA</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>CHESAPEAKE CITY Md.</b> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>DIPPIN FUNERAL HOME</b>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                       |  |  |

Mr. H. B. 88

Memorandum

To : Mr. Tolson

From : Mr. [illegible]

Subject : [illegible]

Reference : [illegible]

Enclosure

Very truly yours,

Special Agent in Charge

cc - Mr. [illegible]

cc - Mr. [illegible]

cc - Mr. [illegible]

cc - Mr. [illegible]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |   |                                    |   |   |                          |  |
|--|---------|------------------------------|--|---|------------------------------------|---|---|--------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                              |  |   |                                    |   |   |                          |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |   |                                    | 2a. DATE KNOWN OF DEATH   |   |                          | 2b. HOUR                                     |
| WILLIAM MICHAEL WELDON   |         |                              | Clinton  |   |                                    | Month Day Year  |   |                          | 9:50   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |                                    | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD |  |
| Male   | White   | Aug. 28, 1956                | 11 YRS   | MONTHS  | DAYS                               | HOURS   | MIN.  | Month Day Year           | 2d. HOUR                                     |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |                          |  |
| Virginia   |         | U.S.A.                       |  |   |                                    | Cecil Md.   |   |                          |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                          | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Elkton near Charlestown  |         |                              | Union Hospital   |   |                                    | Student   |   |                          | --   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |                          | 13e. STREET AND NUMBER                       |
| Md.  |         |                              | Cecil  |   | Perryville                         |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | R.D. 1 Carpenter's Point                     |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |   |                                    |   |   |                          |  |
| First Middle Last  |         |                              | First Middle Last  |   |                                    |   |   |                          |  |
| William Edward Weldon  |         |                              | Barbara Faye Garnett   |   |                                    |   |   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS              |   |   |                          |  |
| No   |         |                              |  |   | Hospital Records                   |   |   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |   |                                    |   |   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning   |         |                              |  |   |                                    |   |   |                          |  |
| 815.1 DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |                                    |   |   |                          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |                              |  |   |                                    |   |   |                          |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |                                    |   |   |                          |  |
| (c)  |         |                              |  |   |                                    |   |   |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |   |                                    |   |   |                          |  |
| 8194   |         |                              |  |   |                                    |   |   |                          |  |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                                    | 20. AUTOPSY?  |   |                          |  |
|  |         |                              |  |   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |   |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |                          |  |
| <input checked="" type="checkbox"/>  |         |                              | 9:05 P.M. 8 7 19 68  |   |                                    | Subject passenger in auto-fixed object throwing him from car into stream                |   |                          |  |
| 21d. INJURY OCCURRED   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or town County State                            |   |                          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         |                              | Stream   |   |                                    | Int. of Rte. 267 Charlestown Cecil Md.  |   |                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |   |                                    |   |   |                          |  |
| ACTUAL SIGNATURE   |         |                              | EXAMINER'S NAME (Type)   |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |                          | 22b. DATE SIGNED                             |
| Edward F. Wilson   |         |                              | Edward F. Wilson, M.D.   |   |                                    | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |   |                          | August 9, 1968                               |
|  |         |                              |  |   |                                    | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |                          |  |
|  |         |                              |  |   |                                    | ADDRESS (Street, city, town, or county)   |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)                       |                          |  |
| Burial   |         |                              | 8/12/68  |   | Washington Mem. Park Cem.          |   | Sandston, Va.   |                          |  |
| 24. FUNERAL DIRECTOR   |         |                              | 25a. REC'D BY REGISTRAR  |   |                                    | 25b. REGISTRAR'S SIGNATURE  |   |                          |  |
| Hicks Home for Funerals, Elkton, Md.   |         |                              | DATE AUG 14 1968   |   |                                    | Charles Judge   |   |                          |  |

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EXHIBIT OF CASE

EXHIBIT OF CASE

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EXHIBIT OF CASE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11460   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 11468  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| First Middle Last<br>Helen Leeds Riley  |  |   |  | Month Day Year<br>8 - 24 - 1968   |  | 7:25 A   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>10-05-87  |  | 6. AGE (In years last birthday)<br>80 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>U.S.A. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Dorchester Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cambridge  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Eastern Shore State Hosp.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Talbot   |  | 13c. CITY OR TOWN<br>Easton   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First Middle Last<br>Samuel Richardson  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Grace Weedon  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>220-52-1555  |  |
| 17. INFORMANT<br>Medical Records E.S.S.H.   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arterio Sclerotic Cardio Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 days   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221 Bronchial Asthma   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (H) (this hospital) attended the deceased from 8-8-68, 19, to 8-24-68, 19, that (H) (we) lost saw the deceased alive on 8-24-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Stephen H Kaufman MD  |  | 22c. DATE SIGNED<br>8/24/68   |  | 22d. PHYSICIAN'S NAME (Type)<br>Stephen H Kaufman   |  | 22e. ADDRESS<br>1004 N Calvert St Balto Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>8/27/1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR BLUFF   |  | 23d. LOCATION (City or Town) (County) (State)<br>ANNAPOLIS, MD                               |  |
| 24. FUNERAL DIRECTOR<br>M E. Newman   |  | 25a. REC'D BY REGISTRAR<br>AUG 28 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>J Charles Judge   |  |  |  |

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CONCORD, N. H.

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